



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR. TODD A TIBBETTS
PO BOX 29407
SAN ANTONIO TX 78229-5907

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative

Box Number 54

MFDR Tracking Number

M4-13-1383-01

MFDR Date Received

FEBRUARY 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed Texas Mutual for 2 Femur X-Rays. We were reimbursed for 1 & the other denied as a duplicate...The medical reports show the x-rays were performed at different times of the day & performed by different providers."

Amount in Dispute: \$14.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor alleges it has not been paid for CPT code 73550 provided on the date above. Texas Mutual paid this service on 9/21/12. (Attachment)"

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2012	CPT Code 73550-26-77	\$14.16	\$14.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC-18-Duplicate claim/service.
- 224-Duplicate charge.

Issues

Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for CPT code 73550-26-77 based upon EOB denial reason codes "CAC-18, and 224."

CPT code 73550 is defined as "Radiologic examination, femur, 2 views."

The requestor appended modifiers "26-Professional component," and "77- Repeat Procedure by Another Physician or Other Qualified Health Care Professional."

A review of the submitted documentation finds that an examination was performed on "08/24/2012 4:00 PM" and another on "08/24/2012 5:11 PM."

Therefore, this is not a duplicate claim because two examinations were performed. Reimbursement is recommended per Division rules and guidelines.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78229, which is located in Bexar County.

The Medicare participating amount for code 73550 in Bexar County is \$8.79.

Using the above formula, the MAR is \$14.16.

The respondent paid \$0.00. The requestor is due \$14.16 additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$14.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$14.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

8/22/2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.